Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 7, 2020	2020_782736_0016	010552-20, 010555-20	Critical Incident System

Licensee/Titulaire de permis

Mill Creek Care Centre
286 Hurst Drive BARRIE ON L4N 0Z3

Long-Term Care Home/Foyer de soins de longue durée

Mill Creek Care Centre
286 Hurst Drive BARRIE ON L4N 0Z3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA BELANGER (736)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 4-6, 2020.

During the course of this inspection, the following logs were inspected:
-two logs, both related to reports submitted to the Director related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Nurse Manager (ANM), Registered Practical Nurse(s) (RPNs), Personal Support Worker(s) (PSWs), Resident Services Attendant(s) (RSAs), Dietary Aide(s) (DAs), and residents.

During the course of the inspection, the Inspector(s) observed the staff to resident interactions, including the provisions of care, reviewed relevant resident charts, relevant investigations notes, relevant staff files, and the licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident (CI) report was submitted to the Director related to an allegation of staff to resident abuse. The CI report indicated that two staff had been attempting to provide care to resident #002, although the resident was refusing the care.

Inspector #736 reviewed resident #002's care plan that was in effect on the date of the incident, under a specific focus, which indicated that the resident was triggered to display responsive behaviours in specific situations and provided the staff with interventions to utilize for the resident.

The Inspector reviewed the licensee's internal investigation notes, which contained a letter to Personal Support Worker (PSW) #103, indicating that they did not follow "the care plan pertaining to responsive behaviours".

In an interview with the Inspector, PSW #103 indicated that although they were aware of the interventions in resident #002's plan of care, they had not followed the interventions laid out in the plan of care related to responsive behaviours and should have. [s. 6. (7)]

2. A CI report was submitted to the Director related to an allegation of staff to resident abuse. The CI report indicated that during an internal investigation, RPN #105 brought forward a concern related to resident #001, involving PSW #103. The RPN indicated that resident #001 was heard yelling, and that PSW #103 indicated that the resident displayed responsive behaviours towards the PSW. The RPN further stated that when they went to assess the resident later in the evening, the resident had skin integrity concerns that were not present prior to care being provided.

Inspector #736 reviewed resident #002's care plan that was in effect on the date of the incident, under a specific focus indicated that the resident may have been responsive and resistive to care during specific activities of daily living (ADLs), and directed staff to utilize interventions to manage the resident's responsive behaviours.

The Inspector reviewed a progress note in resident #001's electronic chart documented by RPN #105, which indicated that the resident had displayed a responsive behaviour, and under the antecedent/triggers listed "poor approach".

In an interview with the Inspector, PSW #103 indicated that although they were aware of the interventions in resident #002's plan of care, they had not followed the interventions laid out in the plan of care related to responsive behaviours on the specific date, and

should have.

In an interview with Associate Nurse Manager (ANM) #102, who was also the lead for the Responsive Behaviour Program, they indicated that staff would refer to a resident's care plan for specific interventions related to a resident's responsive behaviours. The ANM also indicated to the Inspector that staff were to follow the interventions laid out in the resident's individual care plans.

In an interview with the Director of Care (DOC), they indicated to the Inspector that PSW #103 did not provide care as directed to resident #001; or, to resident #002, and should have. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care is provided to the residents as set out in their plan of care, to be implemented voluntarily.

Issued on this 7th day of August, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.